Consumer's Guide to

Grievances and Complaints

A Consumer's Guide to Resolving Disputes with Your Health Plan

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

OCI's World Wide Web Home Page:
oci.wi.gov

PI-217 (C 11/2006)

The mission of the Office of the Commissioner of Insurance . . .
Leading the way in informing and protecting
the public and responding to their insurance needs.

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not recieve satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

For information on how to file an insurance complaint call:
(608) 266-0103 (In Madison) or 1-800-236-8517 (Statewide)
Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
Electronic Mail
complaints@oci.state.wi.us
Please indicate your name, phone number, and e-mail address.
OCI's World Wide Web Home Page
oci.wi.gov

For your convenience, a copy of OCI's complaint form is available at the back of this booklet. A copy of OCI's complaint form is also available on OCI's Web site. You can print it, complete it, and return it to the above mailing address.

A list of OCI's publications is included at the back of this booklet. Copies of OCI publications are also available online at OCI's Web site.

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS

This guide is not a legal analysis of your rights under any insurance policy or government program. Your insurance policy, program rules, Wisconsin law, federal law, and court decisions establish your rights. You may want to consult an attorney for legal guidance about your specific rights.

The Office of the Commissioner of Insurance (OCI) does not represent that the information in this publication is complete, accurate, or timely in all instances. All information is subject to change on a regular basis, without notice.

Printed copies of publications are updated annually unless otherwise stated. In an effort to provide more current information, publications available on OCI's Web site are updated more frequently than the hard copy versions to reflect any necessary changes. Visit OCI's Web site at oci.wi.gov.

The Office of the Commissioner of Insurance does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or the provision of services.

Most people will never have a problem with their health insurance. But when you *do* have a complaint with your plan, it can be difficult to understand the steps you must take to resolve your problem.

This booklet serves as a guide to help you understand the grievance and complaint process you are required to go through for all policies sold in Wisconsin. The question and answer format allows you to read straight through, or go right to a particular question you may have. Also included at the end of the booklet is a series of worksheets that will help you to document your complaint process.

It is important to remember that not all health plans are subject to the appeal process discussed in this booklet. If your plan is self-funded by your employer, then it is subject to federal, not state law. Public programs like Medicare and Medicaid also have their own processes. Make sure you are aware of what kind of health insurance plan you have before you begin the grievance process described in this booklet.

What do I need to know about my health plan?

Is my health plan employer-based, individual, or association?

Employer-based means your employer purchased the health plan and is also the policyholder. Individual health plans are ones you buy yourself and in which you are the policyholder. Association health plans are plans you can purchase through organizations if you are a member.

What are the procedures for my coverage?

If you know the procedures for your coverage and follow them, you will less likely have problems when you do get sick. For example, you need to know exactly how to file a claim, when you might need prior authorization from your plan, when you need to contact the company, who your providers are, and much more. Know these procedures before you need health care in order to minimize trouble when you are already dealing with health problems.

Is your provider in-plan?

If you are in a managed care plan, make sure your provider is in-plan before each visit to ensure you'll receive coverage. You can verify this by checking the plan's Web site and calling your insurer or PPO.

What is covered and what is excluded under my health plan?

You should be aware exactly what medical procedures and medications, etc., are covered under your plan in order to avoid planning a procedure that is not covered.

What if my plan doesn't cover something?

No health plan covers everything—sometimes even health problems that are medically necessary or procedures where there is no other option. It is important that as a consumer you ask your insurer to cover your procedure if you believe you can prove it is an effective treatment or if it is only done on an exceptional basis.

Where do I find answers to these questions?

Review your member material, including your policy and your certificate. You can also call your health plan's customer service number or check with their Web site for this information. If your plan is employer based, you can talk to your employer's human resources section to find answers.

Most importantly, make sure to keep all records. This includes your policy certificate and other member materials, any correspondence from your insurer, letters from providers and/or other documents such as medical records and test results, and also records of all phone calls made to your health plan. The attached worksheets are included to help you document conversations with your insurer.

What if coverage is denied?

If your plan denies your claim or your request for coverage, you will receive a notice. This denial notice (or explanation of benefits) should explain why your insurer denied your claim. Your health plan should give you a specific reason for the denial.

What should I do if I have a complaint?

Many complaints or questions can be resolved informally by calling your plan's customer service line. Many health plans also have Web sites that can be helpful in resolving your complaints. If you have questions regarding how to complain to your insurer, call OCI at 800-236-8517 or visit oci.wi.gov for help filing a complaint.

Most importantly, make sure to keep all records. This includes your policy certificate and other member materials, any correspondence from your insurer, letters from providers and/or other documents such as medical records and test results, and also records of all phone calls made to your health plan.

What if I'm not satisfied with the results of my complaint?

You still have the right to file a grievance. Your denial notice may explain how to do this, or it will tell you how to find these instructions. The denial notice also includes information about your right to have your claim reviewed by an Independent Review Organization.

What is a grievance?

A grievance is any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured. For example, a grievance can be filed when your claim is denied and you believe you need a specialist and your health plan denies this request for a referral, your health plan will not cover a treatment you believe you need, or the quality of your treatment is lacking.

In some cases, an expedited grievance process may be necessary. An expedited grievance means a grievance where any of the following apply:

- The length of time for a normal grievance resolution would result in serious jeopardy to your life or health or would limit the ability for you to regain maximum function.
- Your physician requests the expedited process because your pain is too severe to be adequately managed without the care or treatment that you are requesting.
- Your physician determines that the grievance should be treated as an expedited grievance.

How do I file a grievance with my health plan?

You may file a grievance by sending a letter to your health plan. Keep the following points in mind when writing and sending your letter:

- Identify yourself, including your name, address, and health plan ID number.
- Explain the problem; be specific with dates of service, denial notice, summaries of any phone conversations, and why you believe the plan's decision is wrong.
- Base your argument on policy language; if you are asking for an exception, explain how coverage could benefit the plan—such as avoiding a more expensive treatment that *is* covered.
- Clearly state what you want the resolution of your grievance to be.

- Include photocopies of any supporting documents, such as medical records, referrals, supporting letters from doctors, and articles from peer-reviewed medical journals. If your grievance involves a medical issue, you may want to talk to a doctor and ask if he/she has any records that may support your position.

- Keep the letter business-like.

- If someone else is sending the grievance for you, include a note signed by you authorizing that person to act on your behalf; most plans will require this.

- Send the letter to the address provided on the denial notice or certificate.

What happens next?

Your health plan must send you an acknowledgment within five business days of receiving your letter. If you do not receive an acknowledgment, call your plan. Some plans may review the grievance to try to resolve the problem informally.

Can I be present at the grievance review?

Yes, but you are not required to attend. Your health plan must send you a notice of the time and place of the meeting at least seven days in advance. You have the right to appear in person or by teleconference before the grievance panel where you may present written and oral information and question the decision makers.

The grievance panel must include at least one individual authorized to take corrective action, one insured who is not part of the plan, if possible, and may not include the person who made the initial determination. The panel is not required to include a medical professional, but should consult one when appropriate.

When can I expect to hear from my health plan?

Your plan should send you a grievance resolution letter within 30 days of initially receiving the grievance. They may also choose to extend the decision another 30 days, but must send you a written notice explaining the reason for the extension.

When you do receive a response, it will be in the form of a letter that will either accept or deny your grievance. If your grievance was denied, the letter should explain any additional options, including the right to an independent review. The letter should be signed by one voting member of the panel and include the titles of the panel members.

What is an independent review?

The independent review process provides you with an opportunity to have medical professionals who have no connection to your health plan review your dispute. You choose the Independent Review Organization (IRO) from a list of review organizations certified by OCI. The IRO assigns your dispute to a clinical peer reviewer who is an expert in the treatment of your medical condition. The IRO has the authority to determine whether the treatment should be covered by your health plan.

The independent review process is intended to be an easy way to allow you to receive an independent decision within a relatively short time frame. You can request an independent review whenever your health plan denies you coverage for treatment because it maintains that the treatment is not medically necessary according to their definition, or the treatment it is experimental. You may not request an independent review if the requested treatment is not a covered benefit in your health plan.

Who?

Who performs the independent review?

The independent reviews are conducted by IROs that are certified by OCI. In order to be certified, the IRO must demonstrate that it is unbiased and that it has procedures to ensure that its clinical peer reviewers are qualified and independent.

When?

When can I request an independent review?

You can request an independent review whenever your insurer bases its decision to deny coverage on a medical necessity or an experimental treatment determination. In most cases you cannot request independent review until you have completed the internal grievance process, but you may bypass this process if both you and the insurer agree

or the IRO agrees that a delay in receiving care could jeopardize your health. The claim for which you are requesting an independent review must also meet a minimum dollar amount (which varies) and be requested within four months of the date listed on your grievance resolution letter.

How?

How do I request an independent review?

Choose an IRO from the list provided by the insurer. Then send a written request for independent review to the insurance company.

Be sure to include:

- your name, address, and phone number
- a check for $25 payable to the IRO you choose (this fee will be refunded to you if the IRO resolves the dispute in your favor)
- an explanation of why you believe that the treatment should be covered
- any additional information or documentation that supports your position (photocopies)
- if someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative, and
- any other information requested by your insurer

Your insurer should have provided you with a list of certified IROs and with detailed information on how to request a review with its written grievance decision.

After your insurer receives the information, they must send all relevant medical records and other documentation used in making its decision to the IRO within five business days. The IRO then has five business days to review the information and to request any additional information it may need from the insurer or from you.

Procedure

Then what will the IRO do?

First the IRO will review the request to verify it has no connection to the insurer or health care provider. Then the IRO will review the file to determine if it is complete. You or your insurer may be asked for additional information.

When the IRO has all the information it needs, it has 30 business days to make a decision. The file is forwarded to a clinical peer reviewer who has relevant expertise. In reviewing a case involving medical necessity, the IRO and its reviewer are required to consider all of the documentation, including your medical records, your attending provider's recommendation, the terms of coverage of your health plan, the rationale for the insurer's prior decision, and any medical or scientific evidence. It must limit its decision on a case involving experimental treatment to whether the proposed treatment is experimental. After 30 days, the IRO will send its decision letter to you and your insurer.

What if I need medical attention now?

If you believe you need treatment urgently and cannot wait the 30 days for fear of jeopardizing your health or life, you may be eligible for an expedited process. You physician must agree that the grievance process should be expedited. This expedited process must be settled within 72 hours.

Send your request to both your insurer and the IRO at the same time. The IRO's medical staff will then review your request and has the authority to determine if the grievance process may be bypassed. You will be given a decision in 72 hours or as soon as your health condition requires.

Do I have any other options?

If you have already gone through the grievance process and still are unsatisfied with the results you can:

- File a complaint with OCI.
- Contact the Managed Care Specialist at OCI who will answer questions about your rights and responsibilities, including your right to file a grievance and to an independent review. The Specialist can also assist in urgent situations.
- Hire an attorney.
- Take your complaint to small claims court.

- Your employer may have insurance experts that might be able to help.

- It may also be beneficial to contact the Department of Labor, the Center for Medicare/Medicaid Services, or the Department of Health and Family Services for help with your complaint.

Grievance and Complaints Worksheet

Step 1: Get to know your health plan

Company name: _____

Company address: _____
address city state zip code

Company phone number: _____

My health plan is through:

[ ] My employer
[ ] A policy I bought myself
[ ] An association-sponsored policy (such as through a trade, civic or educational organization)
[ ] Other: _____

What is covered under my health plan:

[ ] Are the doctors, hospitals and other medical providers that I use in the plan's network?

_____

_____

_____

_____

[ ] If I choose to use a doctor outside the provider's network will I be covered?

_____

_____

_____

_____

[ ] Can I change my primary-care physician if I want to?

_____

_____

_____

_____

[ ] Do I need to get permission before seeing a medical specialist?

[ ] What are the procedures for getting care and being reimbursed in an emergency, both at home and out of town?

[ ] If I have a chronic medical condition, how will the plan treat it?

[ ] Are my prescription medications covered by my health plan?

[ ] If I want alternative medical therapies such as acupuncture or chiropractic treatment, will they be covered by my health plan?

[ ] Are all pregnancy-related medical costs covered by the provider?

Step 2: Keep your records

In an event that you may have a complaint in the future, it is important to keep all records relating to your insurance policy.

[ ] Policy certificate
[ ] Medical records/test results
[ ] Letters from providers
[ ] Records of all phone conversations, including

Date and Time: _____

Number called: _____

Name of the plan representative: _____

Summary of the discussion (including any promises made and the estimated time for any payment resolution):

Date and Time: _____

Number called: _____

Name of the plan representative: _____

Summary of the discussion (including any promises made and the estimated time for any payment resolution):

Date and Time: _____

Number called: _____

Name of the plan representative: _____

Summary of the discussion (including any promises made and the estimated time for any payment resolution):

Step 3: Write your letter

Make sure you use the following tips when writing your complaint letter:

[ ] Did I include my name, address, phone number and my policy ID number?

[ ] Did I fully explain the problem, including:

- [ ] dates of service?
- [ ] summaries of phone conversations?
- [ ] reasons I believe the plan's decision is wrong?

[ ] Did I use policy language?

[ ] Did I clearly state my intended resolution?

[ ] Did I include photocopies of all supporting documents?

[ ] If someone else is sending the grievance on my behalf, did I include a note signed by me?

[ ] Did I send the letter to the address provided on the denial notice?